The PREVENTION CONNECTION
NEWSLETTER

Co-occurring Mental Health and Substance Abuse Disorders

by Lou Thompson, Mental Health Services Bureau Chief

Seven to 10 million individuals in the United State have at least one mental disorder as well as an alcohol or drug use disorder. As indicated by the U.S. Surgeon General's 1999 report, "41–65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder."

In light of the extent of co-occurring mental disorders and substance abuse, substance abuse treatment is a critical element of treatment for people with mental disorders. Likewise, treatment of symptoms and signs of mental disorders is a critical element of recovery from substance abuse.

Individuals experiencing both substance and mental disorders simultaneously have particular difficulty seeking and receiving diagnostic and treatment services, even though, separately, these disorders can be as treatable as other chronic illnesses. Decades of treating co-occurring disorders through separate mental health and substance abuse systems have proved the practice ineffective.

Integrated treatment is a means of coordinating both substance abuse and mental health interventions to treat the whole person more effectively. Integrated treatment can improve client engagement, reduce substance abuse, improve mental health status and reduce relapses for all age groups.

Despite strides in the research over the past two decades, little is really known about the cause and origins of co-occurring substance abuse and mental disorders. These disorders can relate to one other in one of three ways:

1) the disorders may occur independently of one another;
2) the mental disorder may place an individual at greater risk for substance abuse disorders; and
3) drug abuse intoxication or withdrawal may result in temporary mental disorder syndromes (NASMHPD/ NASADAD, 1999).

Two decades or research and theories of the causes or origins of co-occurring disorders can be synthesized into four general models (Mueser et al., 1998).

Common factor models: High rates of co-morbidity are the result of risk factors in both severe mental illness and substance abuse disorders. Risk factors include low socioeconomic status or relationship loss and bereavement, which can increase vulnerability to mental illness or substance abuse for individuals, groups and communities.

Secondary substance abuse disorder models: Severe mental illness increases a person's chances of developing a substance abuse disorder.

Continued on Page 2

Co-occurring Disorders

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604
Web Site: www.prevention.mt.gov

Director
Vicki Turner
(406) 444-3484
vturner@mt.gov

Ernie Chang
VISTA Leader
(406) 444-3925
echang@mt.gov

Jim Burton
PRC Technician
(406) 444-9654
jburton@mt.gov

The Vicki Column

The last issue of the *Prevention Connection* focused on some painful childhood issues—in many cases, the kinds of situations that can lead to long-term consequences in quality of life for the child, the family and the community. Research is revealing that childhood trauma, in particular, is connected with long-term problems. We know without a shadow of a doubt that low socioeconomic status, family conflict and exposure to violence can all have horrific consequences for children and youth. Exposure to these and other risk factors—particularly without the balancing effect of protective factors—can lead to numerous teen risk behaviors. Some of those risk behaviors involve the use of alcohol and drugs. We also know that the earlier the age of onset for substance use, the more likely it is that the individual will experience abuse and/or dependence at some point in his/her life. Researchers increasingly suspect that some of the risk factors for mental and substance abuse disorders are identical.

Perhaps we'll never definitively know if alcohol and drug abuse lead to co-occurring mental health disorders—or if underlying mental health disorders lead to co-occurring substance abuse. It comes down to a chicken or the egg debate—and perhaps the truth lies in the fact that every story is unique. Even so, the better we get at preventing substance use among our children and youth, the better our chances will be to see a decline in the prevalence of co-occurring substance abuse and mental health disorders.

This issue of the *Prevention Connection* provides a snapshot from a place on the continuum that our publication doesn't often approach. Unfortunately, co-occurring disorders are so common that they have come to be the expectation among mental health and substance abuse treatment providers. These are complicated, painful problems that destroy countless lives.

We continue to believe that prevention is one of our most valuable paths to real solutions. Preventing substance use among children and youth is an excellent first step toward getting a handle on addressing co-occurring disorders.

Vicki

Co-occurring Disorders

Continued from cover

Secondary mental/psychiatric disorder model: Substance abuse can precipitate severe mental illness in people who would not otherwise develop it.

Bi-directional models: Either severe mental illness or substance abuse disorders can increase a person's vulnerability to developing the other disorder.

Since 1995, when the Mental Health and Chemical Dependency bureaus were administratively organized within the Addictive and Mental Disorders Division, the emphasis has been on delivering services appropriate for co-occurring disorders. Despite barriers created by separate funding streams, credentialing, licensing and disparate provider networks, the Mental Health and Chemical Dependency bureaus have resolved to meet the needs of individuals with co-occurring disorders within the resources available.

> ***Many researchers and clinicians believe that both disorders must be considered primary and treated as such.***

In the fall of 2003, a Co-occurring Task Force drafted a charter document that incorporated a vision for integrated system development with an action plan and the steps necessary to create a co-occurring capable system of care. The work will be done using the Comprehensive, Continuous, Integrated System of Care Model (Minkoff and Cline). This model was designed for implementation within the context of current service resources and emphasizes strategies to improve services and reduce the duplication of services.

For more information, contact Lou Thompson, Chief, Mental Health Services Bureau (lothompson@mt.gov) or Joan Cassidy, Chief, Chemical Dependency Bureau (jcassidy@mt.gov).

The Prevention Connection

Sherrie Downing
Editor
(406) 443-0580
Fax: (406) 443-0869
E-mail: DowningSL@bresnan.net
www.sherriedowning.com

Karen von Arx Smock
KD Graphics
Freelance Design & Production
Phone/fax: (507) 894-6342
E-mail: kdgrafix@acegroup.cc

Notes From the Edge

by Suzanne Hopkins

—Although I never became a physician, nor a psychopharmacologist, I have certainly studied drugs from the other side.

I was raised in an Irish-Catholic family of bartenders and priests in the 1950s and 60s. My grandfather owned a bar, my father was a bartender and my uncle, a monsignor, had the best liquor cabinet of all.

Drinking accompanied every social event in my life and my parents had plenty of parties. After each of these parties, I would go around the next morning and finish all the drinks from the night before. I guess I was about 7 or 8 when I really remember getting up especially early, before everything got cleaned up.

When I was in high school, and my friends discovered the "joys" of alcohol, I was already ahead of them. From the earliest times, I out drank everyone. While I was practicing for my high school graduation, I had my first experience with hashish and marijuana. I liked them, too.

After graduating, I ran away to Haight-Ashbury, where I found drugs of all kinds: LSD, *speed*, *weed*, *hash* and other powders with various names. I really liked the LSD and the speed. In fact, the speed helped me stay awake as many hours as a "normal" person—without any drugs, I usually slept 12-18 hours a day.

When I was in college, I went to a school psychiatrist who explained that my sleeping was due to depression, and he prescribed antidepressants. The antidepressants were not as sophisticated as they are today, and made me sleep even more *and* eat way too much—just what I needed! I decided to stick with the illegal drugs and alcohol, which made me feel the way I wanted to feel.

My best years, when I did the best in school as well as worked in the medical field (I wanted to be a physician or psychopharmacologist), were when I had all the drugs I wanted. As the drugs became harder to find, I took more risks to get them, and learned very quickly how to write my own prescriptions.

If this sounds like a prescription for catastrophe, it certainly could have been, but I was very, very lucky—until the risks I was taking and the cost of the drugs got too high for me to use regularly. Then it was a constant up and down. When I couldn't find any illegal drugs, I drank scotch and later brandy. For the last few years, when I lived in Baja California and Jamaica, I drank a quart of booze a day. I also learned to read the Mexican Physician's Desk Reference (PDR) and found drugs there that worked pretty well, although I still drank heavily.

While I was in Jamaica, I had an experience that made me realize I was poisoning my mind and body and went to my first Alcoholics Anonymous meeting. I subsequently went into a 30 day treatment program in Montego Bay, then returned to Los Angeles to live with an old boyfriend.

As soon as I stopped using drugs and alcohol, my lifetime depression came back as well as Attention Deficit Disorder (ADD), which I didn't know about until sometime later. I tried and tried to stay away from alcohol and other drugs, but failed miserably—which made me even more depressed. My boyfriend finally had enough of me and told me I had to leave. My sister was living in Lewistown, Montana at the time, and asked me to come and visit. She said there was enough room with her and her family for me to stay as long as I wanted. I packed up everything I could carry on the train and moved to Montana.

All of my siblings had alcohol and drug problems, and one sister killed herself when she was 21. My brother, who had obvious ADHD, had been in trouble with the law since he was in his early teens. He liked lots of drugs and driving in excess of 100 miles an hour on his bike. My brother died several years ago in Bogata, Columbia—where he had gone to have more access to cocaine and marijuana. The sister who invited me to Montana had had serious problems with alcohol, so had decided to stick with marijuana. I finally saw what drugs were doing to my sister's family, and decided they must be affecting me the same way. I started to go to 12-Step meetings again—but my ADD and depression devastated me once again.

I started seeing a therapist at the Community Mental Health Center, who

Continued on Page 4

Notes From the Edge

Continued from Page 3

helped me realize what was really happening in my life, why I was having so much trouble with alcohol and meth. She referred me to a psychiatrist in Billings. When the doctor diagnosed me with depression, I was not surprised. When he also diagnosed Attention Deficit Disorder, I was thrilled to find a reason behind some of the problems I had with completing projects, acting in dangerously impulsive ways and being addicted to amphetamines, and that it had a name. That was the beginning of my healing.

The psychiatrist said he would treat my depression and ADD if I would give him my word I would not use alcohol or non-prescribed drugs. I agreed and began treatment. For months, I railed at my therapist about the stupidity of doctors who prescribed medicine in doses that wouldn't even help a child and who couldn't see that something wasn't working, but I kept to my agreement not to use anything my doctor didn't prescribe. Finally some of my symptoms got a little better, which reinforced the idea that I was doing the right thing.

Now, after nearly 10 years, I wish I could say that from then on it was easy. It wasn't. I still have dreams of being able to drink "like a normal person," and many times when I am tired or lonely, I wish I had some meth. But I *am* able to put those thoughts aside, thanks to my medical team, my significant other and my Higher Power.

I am also grateful to be able to help the Addictive and Mental Disorders Division and NAMI-Montana by giving my personal insights into these issues, which are at the forefront today. I feel I can help just by sharing my past and present with those who want help or who want understand what it is like to have a serious mental illness and alcohol and other drug problems.

One Plus One Does Not Equal Two:
Mental Health and Substance Abuse

by Deborah Matteucci, Montana Mental Health Association

Montana treatment providers have come to view co-occurring disorders as an expectation, not an exception.

The primary reason people do not respond to substance abuse treatment is underlying mental illness, while the reason people do not respond to mental health treatment is because of underlying substance abuse issues. At least 50 percent of both populations are struggling with the effects of substance abuse and diagnosable mental illness.

Montana State Hospital clinical staff report that substance abuse is a primary factor in at least 20 percent of admissions, and that 58 percent of the patients admitted during State Fiscal Year 2004 had a co-occurring substance abuse problem that was at least a contributing factor to admission.

Mental illness can strike anyone. It does not respect age limits, economic status, race, creed or color. During the course of a year, more than 54 million Americans are affected by one or more mental disorders. We *all* face a lifetime risk of having a depressive episode at some point and may face more severe and disabling illnesses including schizophrenia, bi-polar disorder, clinical depression or acute anxiety. Some will seek treatment. Many will not.

As Montanans, we pride ourselves on our rugged individualism, independence and self sufficiency. Unfortunately, these characteristics can also prevent us seeking the very care that we desperately need.

It is sometimes easy to forget that the brain, like all other organs, is vulnerable to disease. People with mental illnesses often exhibit behaviors such as extreme sadness and irritability, and in severe cases, may suffer from hallucinations and total withdrawal. Instead of being treated with compassion and acceptance, people with mental illnesses often experience hostility and discrimination. They are stigmatized and often shunned.

Medical science has made incredible progress toward understanding the causes of many diseases—including mental illnesses—over the last century. Doctors continue to solve some of the mysteries of the brain. However, many cognitive functions remain a mystery. No one fully understands how the brain works or why it malfunctions. Researchers have determined that many mental illnesses are the result of chemical imbalances in the brain. Often, people will seek alternative ways of treating these imbalances and will turn to drugs or alcohol as a way of self-medicating.

Studies over the past ten years indicate that the prevalence of substance abuse disorders in people with severe mental illness is higher than in the general

Continued on Page 5

One Plus One

Continued from Page 4

population. Over 50 percent of all persons aged 15–54 with a mental or addictive disorder also have at least one other co-occurring disorder. The combination of these disorders can be devastating. Persons with severe mental illness such as schizophrenia and bi-polar disorders are probably unaware of the consequences of their alcohol or drug use. Many will also face the heightened risk of misuse of prescribed psychiatric medications, either through missed doses, inaccurate dosing or abandonment of the treatment program. Complications can arise, including exacerbation of the psychiatric symptoms, increased need for hospitalization, disruptive behavior and decreased social functioning. These vulnerable consumers face a greater risk of health problems, and their physical safety is often jeopardized. They are alienated, confused and in desperate need of care.

MMHA: Bringing mental illness out of the darkness and into the light!

To further complicate the situation, the stigma attached to these illnesses works against recovery, opportunities for treatment and expectations of healthy and positive outcomes. Often the systems designed to support persons with mental illness and substance abuse issues inadvertently add to the stigma by refusing services for one condition or the other—or through poorly coordinated care. In spite of consistent evidence regarding the needs of persons with co-occurring disorders for coordinated, comprehensive and integrated services, many stakeholders in the policy, prevention and treatment fields continue to remain divided on key issues. The debate includes best use of tight financial resources and about what effective treatment for persons experiencing co-occurring disorders is. Often, individuals with co-occurring disorders must seek and receive treatment from two separate systems, providers or teams of providers. Unfortunately, they may even find themselves excluded from one or both systems because of the complicating features of one type of disorder or the other.

This is a public health crisis that needs attention today. For more information on how you can help fight stigma, educate the public and advocate for those who cannot speak for themselves, contact Deb Matteucci of the Montana Mental Health Association at. *mmha@qwest.net* or visit them on the web at *www.mhamontana.org*.

What can we do to improve?

Integrated Service Models—Coordinate service delivery. Persons with co-occurring disorders need access to seamless services with a "no wrong door" approach.

Blended Funding Streams—Advocate for pooled funding streams on the federal and local levels. Target these funds for a continuum of integrated treatment programs for persons with co-occurring disorders

Increase service appropriations—Provide adequate funding. Under-funded programs inhibit the development of collaborative or integrated service delivery models and deters primary care physicians from addressing mental health and/or substance abuse issues, even when the symptoms are fairly clear cut.

Community cross-agency service system cooperation—Encourage substance abuse and mental health providers to work in close collaboration, and with social service providers such as vocational rehabilitation or housing services, to provide a comprehensive continuum of care.

Agency Integration—Cross train the treatment teams. At a minimum, providers should be trained in basic knowledge of core elements of mental health or substance abuse issues, and encourage partnerships with professionals from other agencies to increase capacity to provide effective service.

Support services for persons with co-occurring disorders—Encourage development of consumer-led support groups, such as Dual Recovery Anonymous, to meet the specific and unique needs of persons with co occurring disorders. The level of confrontation in a traditional 12-step group can feel overwhelming to some individuals with a mental illness. In addition, the use of psychotropic medication in substance abuse recovery has been a controversial issue in some areas of the substance abuse recovery community.

A Snapshot

Among adults with Serious Mental Illness (SMI) in 2002,

- *an estimated 4.0 million adults also met the criteria for substance dependence or abuse within the year prior to the survey;*
- *2.4 million were dependent on or abused alcohol only. About 0.8 million abused illicit drugs in addition to alcohol. Approximately 0.9 million were dependent on or abused an illicit drug only;*
- *the percentage of those dependent on or abusing illicit drugs (23.2 percent) was almost 3 times the percentage of that for adults without SMI (8.2 percent); and*
- *the percentage of binge drinkers was greater than that of the non-SMI population: 28.8 percent were binge drinkers. In the non-SMI population, 23.9 percent of adults were binge drinkers.*

Source: prevention partners.samhsa.govstat_ depression.asp

Montana Heroes: *Cindy Dolan*

by Sherrie Downing, Editor

—Agape: a Greek word meaning "God's unconditional love."

In a certain place in Great Falls, there's grass where there used to be cement. A tumbledown motel has been converted to transitional housing for young adults between the ages of 18–21. The apartments have new appliances, new paint, new carpet and more. The *Agape Youth Investment Center* is a transitional living center for young adults coming out of group homes, foster care . . . off the streets and out of homelessness. An estimated 80 percent struggle with co-occurring substance abuse and mental health disorders.

The Agape Center can serve up to 15 kids at a time; most of the time 8–12 live on-site, each in his or her own apartment. The rules are strict and there are a lot of them. There can be no weapons of any kind and every resident is required to engage in productive activity (e.g., school or work) for at least 35 hours a week. Once accepted, a resident has two weeks to find a job. Residents are expected to pay rent of $300/month or 1/3 of their income, whichever is less. If they don't have income, they must work for their room and board. Each resident must report in to Agape staff daily.

In a May 2000 survey administered by Opportunities Inc., 2,800 Great Falls kids in grades 6–12 were asked,* Where do you live? In an apartment, a house, a trailer, a group home, in a residential treatment facility, or are you homeless? *That day, 28 kids said they were homeless. School administrators estimated that more than 100 kids had been homeless over the course of the year. These kids were in and out of people's homes, staying in cars, in the parks . . . living in unstable—often unsafe—environments.

White Bison *Wellbriety* sessions are held once a week. Sunday nights, there is a gathering to talk about the five areas of health. Tuesday and Saturday nights there are mandatory communal meals. Two adults live upstairs to provide security at night and to serve as house parents.

Everyone who lives at Agape goes through an intake process run by a community advisory board. Members have to be convinced that the prospective resident can live independently and by the rules. Not everyone who applies gets in; those who *do* get in commit to working—hard—toward the goals they set for themselves. Some aren't ready and don't make it. Most do.

Though she shies away from the credit, a lot of the reason the *Agape Youth Investment Center* exists is because of the vision and dream of one woman. Cindy Dolan. There were dozens and dozens of heroes involved in bringing Agape to fruition—thousands of hours of elbow grease and a quarter of a million dollars of in-kind and direct donations. But in the beginning was Cindy Dolan's question: *What can we do for the children?*

As a concerned citizen, Cindy knew she needed to get people to gather, to talk about some of the things that were so clearly going wrong for local kids. She began asking around. *Who should be at a meeting?* She hoped to gather a dozen names—to her surprise, she soon had over 100. Cindy invited all of them to a meeting and more than half showed up. They included everyone from the local sheriff and police officers to school personnel. There were representatives of the faith community, youth partnerships and civic organizations.

The group spent more than two hours identifying the gaps that let kids fall through the cracks. Three stood out right away: truancy was a problem, as were issues disproportionately affecting Native American children and youth. Shelter was the third. With this conversation, the *Save the Children Coalition* was born. Soon they had a mission: *To identify service gaps for underserved children in our community and to develop a multi-systemic approach to fill these gaps.*

The new coalition began holding forums on each of the three identified issues.

Continued on Page 7

Early Life Trauma and Adolescent Risk

Early life trauma can prime the brain for a later presentation of PTSD. The presence of depressive symptoms is the rule and not the exception for adolescents with a history of early life trauma. Children who are maltreated have a greater incidence of developing numerous problems during their preadolescent and adolescent years:

— Violent behavior
— Criminal activity
— Teenage pregnancy
— Psychiatric disorders
— Substance abuse
— Self-destructive behavior

These same children will have a higher incidence of numerous psychiatric disorders, including substance abuse:

— Attention-Deficit/Hyperactivity Disorder
— Oppositional Defiant Disorder
— Clinical Depression
— Bipolar Disorder
— Phobias
— Obsessive Compulsive Disorder
— Oppositional Defiant Disorder
— Generalized Anxiety Disorder
— Borderline Personality Disorder
— Conduct Disorder
— Eating Disorders
— Somatoform Disorders
— Panic Disorder
— Posttraumatic Stress Disorder

Source: Another Chance: Treating Early Life Trauma Issues in Adolescents Suffering from Addictive Disorders by Cardwell C. Nuckols, Ph.D. Counselor, the Magazine for Addiction Professionals, April 2004, v.5, n.2, pp. 48-52. (http://www.counselor magazine.com/)

Montana Heroes: Cindy Dolan

Continued from Page 6

Between 20 and 40 people would show up at each forum. Experts would speak for a few minutes, then participants would share their perspectives. When they began coming up with to-do lists, Cindy would ask, *Is anyone willing to work on this?* Half would say yes. Half of those would show up to work.

Transitional shelter for young adults was one of the big missing pieces. Many had nowhere to go, nowhere to turn. A shelter was badly needed, but the group simply didn't have the resources it would take to create one. Then a friend called Cindy to tell her about an old motel that was up for sale. It was perfect—or it would have been if it hadn't been way out of reach for the coalition. Then, to Cindy's surprise, an unnamed benefactor stepped forward to pay $180,000 for the motel and deeded it over to *For the Children*, free and clear. She's the one who chose the name *Agape*—for *God's unconditional love*.

Owning the building was a huge first step toward making the center a reality, but there was lots more to do before the rundown motel could be used as safe, decent housing. The transformation would be expensive. Hoping for assistance or advice, Cindy approached the manager of the local Home Depot. He listened quietly, then said, *"We'll help. I was once a 17-year old kid who didn't have a place to go."* Home Deport ultimately provided $15,000 in supplies; their employees donated hours and hours of labor.

From there, the work began in earnest. *Save the Children* members worked hard from July until October 2002, cleaning, clearing, painting, carpeting. A local plumber donated time and equipment. First Interstate and Northwestern Energy went in on a new boiler. A grant came through, and suddenly there were three new furnaces and an air conditioner. Someone donated the materials and labor for the landscaping. And there was still more to do.

Then staff from the *Prerelease Booter Program* approached Cindy. Residents of the Department of Corrections Boot Camp are required to perform community service. Cindy said that their help would be welcome, and suddenly men started showing up four days a week, 10 hours a day. A few believed in the project so strongly that they began coming back to help on their own time. Volunteers and donations from churches and schools poured in. A small-town high school gathered baskets of supplies for the apartments; over $1,000 in toiletries and funding came from a statewide church convention. Then, finally, came the day when Agape could offer safe, supportive housing for the young people who had nowhere else to go.

By now, around 25 kids have come through the program. They come looking for safety, for the end of victimization, for ways to stay away from a bad crowd. Without the Agape Center, most would have had no options other than homeless shelters or the streets.

Cindy's eyes light up when she tells about some of Agape's success stories. No one would have thought *Chad would ever be counted as a success story. Addicted to marijuana and mushrooms, he spent most of his time talking about the "good old days" when he had a coffee table full of pot. Chad found his way to Agape and tried the program, but couldn't make a go of it. He moved out and started falling apart—fast. A friend brought Chad's deteriorating condition to the attention of Agape staff. His drug abuse had always been obvious. His mental illness had not. Chad went into the hospital, and for the first time admitted that he'd been hearing voices for years—that he used drugs to quiet the voices. Since receiving treatment for his schizophrenia, he no longer uses drugs. Once stable, Chad was able to go home. These days, he's in college and doing very well.

Cindy Dolan says that Chad wasn't Agape's first success story, nor will he be the last. But she'll be the first one to say that she is only one of hundreds of heroes who together provided the foundation for those success stories. In the end, it doesn't matter who gets the credit because everyone wins. Kids, families . . . the community. Ultimately it's in the *giving* that anyone receives. And that's the secret of the Agape Youth Investment Center.

For more information, contact the Agape Youth Investment Center at 406-452-1667.

*The name has been changed to protect confidentiality.

Kids' Reactions to Trauma

Reactions to trauma may appear immediately . . . days and even weeks after a traumatic event. Loss of trust in adults and fear of the event occurring again are common responses seen children and adolescents, but other reactions may vary according to age.

***For children 5 and younger,** typical reactions can include fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, and excessive clinging. Children may also exhibit regressive behaviors such as thumb-sucking, bedwetting and fear of the dark.*

***Ages 6–11:** may show extreme withdrawal, disruptive behavior and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. The child may complain of stomachaches or other bodily symptoms that have no medical basis.*

***Ages 12–17:** may exhibit flashbacks, nightmares, emotional numbing, avoidance of reminders of the traumatic event, depression, substance abuse, problems with peers and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances and confusion.*

Source: Helping Children and Adolescents Cope with Violence and Disasters. National Institute of Mental Health. http://www.nimh.nih.gov/

Suicide, Substance Abuse and Mental Illness

by Thom Danenhower and Debby Henderson

In 2002, Montana came in second in a contest nobody wanted to win: we had a higher suicide rate than any other state except New Mexico. That year, 182 Montanans—or 19.6 of every 100,000 residents—succeeded in taking their own lives. In 2003, another 179 Montanans were lost to suicide.

This is a long-standing problem in Montana. Data compiled by the U.S. Centers for Disease Control and Prevention shows that between 1989–1998, the state averaged 167 suicides annually. According to Lloyd Potter, Director of the Suicide Prevention Resource Center (SPRC) in Newton, Massachusetts, substance abuse and/or mental illness play a significant role in up to 70 percent of suicides.

Those most likely to resort to suicide are Caucasian males over age 65. They accounted for 20 percent of all suicides between 1995–1998. They are 64 percent more likely than teens to orchestrate their own deaths. According to the *2004 Montana Suicide Prevention Fact Sheet* by the SPRC, the leading method for suicide completion during this period was with a firearm, at a rate of 13.6/100,000. Poisoning was the next leading method with a rate of 3.6/100,000. A 1997 study of suicide in Montana found that because men favor firearms and because firearms are more lethal than poison, 60 percent of hospitalizations related to suicide attempts involved females, primarily between the ages of 14 and 19. Ninety percent of them had used poison. Medical and other costs were estimated at $16,445 per case, or over $13 million annually.

For the past several decades, Montana has ranked among the top five states for the highest rates of youth suicide. As revealed by the *2003 Youth Risk Behavior Survey*, 26 percent of high school students in Montana reported they "felt so sad or hopeless almost every day for two weeks or more in a row" that they "stopped doing some usual activities." About half of all Montana high school students had used alcohol within the past 30 days, and over 6 percent reported that they had attempted suicide in the past 12 months.

In light of the scope of this problem among teens in 2003, the Governor's Office chose to focus on preventive efforts among the youth population. It allocated $50,000 to the Montana Department of Public Health and Human Services (DPHHS) and local coalitions and tribal groups for suicide prevention efforts.

Last year, the Family and Community Health Bureau of DPHHS conducted a survey to help determine the resources and needs of communities interested in youth suicide prevention. The bureau sent a project assessment survey to a wide array of community mental health and other suicide prevention stakeholders. A total of 751 responses were returned. Final analysis indicated that over 72 percent thought their community had a significant unmet need for suicide prevention, while only 21 percent thought youth in their community were receiving the treatment they needed for depression and other mental illnesses. At the same time, 80 percent indicated that access to youth behavioral resources was a problem.

Educating the public concerning suicide risk and protective factors is crucial. This year, $10 million is available through the federal *Garrett Lee Smith Memorial Act*; about half will go to states for development of statewide and tribal early intervention and prevention programs. The act also provides around $5 million dollars in grant funding to states for development of state-sponsored statewide or tribal youth early intervention and prevention programs in a range of settings including schools and the juvenile justice system. The funding could provide support to public organizations actively involved in state-sponsored efforts for statewide or tribal youth suicide early intervention and prevention strategies. The act also provides for data collection and for monitoring program effectiveness.

Montana health officials will continue to work to move the state to the bottom of the heap when it comes to our suicide rate. This is one contest in which we'd be proud to claim last place. For more information, contact Thom Danenhower, Injury Prevention Coordinator, EMS & Trauma Systems Section, DPHHS at *tdanenhower@mt.gov*.

Suicide in Montana

In 2003, Montana had 179 suicides: 146 males and 33 females.

Age and Gender

— 13 suicides were among youth aged 10 –19: 10 males and 3 females

— 47 aged 20 – 34: 38 males, 9 females

— 72 aged 35 – 54: 57 males and 15 females

— 47 age 55 or older: 41 males and 6 females

Method and Gender

— Firearm (66.5%) —119 suicides: 105 males

— Hanging (17.3%) – 31: 29 males

— Poisoning (14%) – 26: 10 males

— Other – 3 suicides

For more information, visit www.dphhs.mt.gov/. *Click on "Services" on the top right, then click on "Vital Statistics" on the pull-down menu.*

Sources Cited:

1. Montana Department of Public Health & Human Services Vital Statistics, 2002 and 2003. (*www.dphhs.mt.gov/divisions/otd/vital/statistical_tables.htm*)

2. *Montana Suicide Prevention Fact Sheet,* Suicide Prevention Resource Center, , Newton, Massachusetts, 2004. (*www.sprc.org*)

3. Montana Youth Risk Behavior Survey (YRBS) Conducted by the Montana Office of Public Instruction (OPI), 2004.

4. Youth Suicide Prevention in Montana, Draft Progress Report, Montana DPHHS, 2004.

Co-occurring Disorders Increase Risk of Adolescent Suicide

—Co-occurring mood disorders place both males and females with substance use disorders at highest risk for attempting suicide.

Research has shown that adolescents with substance use disorders are most likely to attempt suicide when they also have a co-occurring mood disorder. NIDA-funded scientists at the University of Pittsburgh have extended this research and found that in general, both male and female substance abusers who attempt suicide begin taking drugs at an earlier age and have more symptoms of psychiatric and substance use disorders than adolescents who do not attempt suicide.

Dr. Thomas Kelly and his colleagues collected data from 188 females and 315 males, aged 12 to 19 years, who were diagnosed with an alcohol or substance use disorder and who participated in studies between 1991–2000 at the Pittsburgh Adolescent Alcohol Research Center. Overall, 29 males and 56 females had made one or more suicide attempts during their lifetimes. Males with hallucinogen use, inhalant use, sedative-hypnotic use and attention-deficit hyperactivity disorders were more likely to have attempted suicide than their male counterparts who had not been diagnosed with these disorders. Males who had attempted suicide also had more symptoms of mood, alcohol, and disruptive behavior disorders and demonstrated an earlier age of onset for conduct and alcohol use disorders.

Females with conduct and substance use disorders (other than cannabis use disorders) were at higher risk for attempting suicide than females who were not diagnosed with conduct disorders or substance use disorders. Females who attempted suicide had more symptoms of substance use and mood disorders compared than their counterparts. Females with mood disorders who had attempted suicide also had an earlier age of onset for those mood disorders.

Researchers found that the risk of attempted suicide among youth with substance abuse disorders begins to increase at about age 11 for females and 12.5 for males. Co-occurring mood disorders place both males and females with substance use disorders at highest risk for attempting suicide.

Source:

National Institute on Drug Abuse, National nstitutes of Health. http://www.drugabuse.gov/newsroom/04/NS-04.html. *Origially published in the January 2004 issue of Drug and Alcohol Dependence.*

. . . In the Juvenile Justice System

—75–95% of youth in the juvenile justice system with a mental health disorder also have a substance use disorder, as compared to 16% of youth in the general population (Cohen et al., 1993; Milin et al., 1991; Otto et al., 1992).

Although there are youth involved with the juvenile justice system who have either a mental health disorder *or* a substance use disorder, many have both. The frequency of co-occurring disorders is very high in the juvenile justice system. The relationship between mental health and substance use disorders is variable and the prognosis poor if youth are left untreated. The assessment, treatment and management needs of a juvenile offender with co-occurring disorders are different from the needs of a juvenile offender who has only one of these disorders.

There are several ways in which substance use and mental health disorders affect each other.

— ***Create—***Substance use can create psychiatric symptoms.

— ***Trigger—***Substance use can trigger the emergence of some mental health disorders if a youth is predisposed to mental illness.

— ***Exacerbate—***Symptoms of mental illness may get worse when a youth uses alcohol and drugs.

— ***Mimic—***Substance use can look like symptoms of a psychiatric disorder.

— ***Mask—***Symptoms of mental illness may be hidden by drug and alcohol use.

— ***Independence—***A mental health disorder and substance use disorder may not be related to each other, but a common factor may underlie them both.

Some have suggested that mentally ill youth "self-medicate" with alcohol and drugs. Others suggest drug and alcohol use is a major risk factor in the development of psychiatric symptoms. At this time, the *exact* relationship between mental illness and substance use is unclear. However, what is clear is that a youth with co-occurring disorders is at greater risk for multiple problems.

Youth with co-occurring disorders are likely to experience:

— Quicker progression to substance abuse after initial substance use;

— Higher dropout rates in substance abuse treatment (particularly if they have conduct disorder); and

— Higher rates of suicide.

Source:

National Gains Center for People with Co-occurring Disorders in the Justice System. www.gainsctr.com/curriculum/juvenile/mod_02_B_02.htm

More on Trauma

"The nature and impact of trauma remains too often misunderstood or neglected." — Charles Curie, SAMHSA Administrator

According to SAMHSA's National Survey on Drug Use and Health, in 2003, an estimated 4.2 million persons 18 and older met diagnostic criteria for both serious mental illness and a substance use disorder (dependence or abuse) in the past year. Of these, 2.0 million were male and 2.2 million were female.

The Substance Abuse and Mental Health Services Administration (SAMHSA) conducted the *Women, Co-occurring Disorders and Violence Study* over a 5-year period. It included more than 2,000 women who had co-occurring mental and substance abuse disorders as well as histories of trauma. Women with these profiles were recruited into two groups: one that received integrated services, and one that received standard care, treating mental health, substance abuse, and trauma issues in isolation from one another. The women who received integrated counseling improved more than the control group. Women's symptoms also improved when they participated in the planning, implementation and delivery of the integrated services.

The study results confirm clinical recommendations by SAMHSA, which hold that treating substance abuse issues without addressing a woman's history of violence is ineffective, and that all clients in substance abuse treatment programs should be assessed for domestic violence and childhood physical and sexual abuse.

There are some strong implications for prevention in this study. Providing children and youth with safe places, changing the community norms around drug and alcohol abuse and promoting healthy parenting practices all work to help prevent the physical and sexual abuse of children.

A Few Facts about Trauma

In mental health and substance abuse service settings

— As many as 80% of men and women in psychiatric hospitals have experienced physical or sexual abuse, most of them as children.

— The majority of adults diagnosed with Borderline Personality Disorder (81%) or Dissociative Identity Disorder (90%) were abused as children.

— Up to two-thirds of men and women in substance abuse treatment report childhood abuse or neglect.

— Nearly 90% of alcoholic women were sexually abused as children or suffered severe violence at the hands of a parent.

In childhood and adolescence

— 82% of young people in inpatient and residential treatment programs have histories of trauma.

— Violence is a significant causal factor in 10-25% of all developmental disabilities.

In the criminal justice and juvenile justice systems

— 80% of women in prison and jail have been victims of sexual and physical abuse.

— In one study, 92% of incarcerated girls reported sexual, physical or severe emotional abuse.

— Boys who experience or witness violence are 1,000 times more likely to commit violence than those who do not.

Source:

The Damaging Consequences of Violence and Trauma, 2004, compiled by Ann Jennings, PhD. http://www.nationaltraumaconsortium.org/

Girls: Special Concerns

— The effects of substance abuse are magnified in females; a woman with bipolar disorder is approximately 7 times more likely to have a substance use diagnosis than a woman without the disorder.

— Early cigarette smoking appears to prime the brain to be more responsive to other drugs, including cocaine.

— Teenagers become addicted faster than adults.

— Street drugs (such as marijuana, cocaine, and ecstasy) as well as nicotine can cause psychiatric symptoms.

— Smoking pot can cause psychosis and hostility, destroy a girl's motivation for learning and achievement, and render her incapable of concentrating or comprehending what she reads (these are also symptoms of schizophrenia, which typically emerges in the late teens and early twenties).

— An increase in these symptoms during the teenage years, or any level of known substance abuse, should be a red flag for parents

— Research demonstrates that earlier interventions make recovery more likely.

Source: Girls with Bipolar Disorder – Special Concerns. Martha Hellander, J.D. Child & Adolescent Bipolar Foundation Research Policy Director. http://www.athealth.com/Practitioner/Newsletter/FPN_9_1.html

The Medicine Wheel & Recovery

by Jenna Caplette

Recovery isn't a linear process . . . In fact, the idea of linear is about black and white thinking, which is addictive thinking, about moving from problem to solution. The Medicine Wheel asks that we think in circles, cycles and options. The wheel is constantly turning, whether we want it to or not. We're all born. We will all die. It's about understanding the consequences of the choices we make. **—Jamie Martin**

Jamie Martin works as a licensed addiction counselor with pre-release prisoners in Butte. Eighty percent of his clients are male. Most are white. What's different about Jamie's approach to treatment for drug and alcohol recovery is that he teaches clients to work with the Medicine Wheel, a Native American symbol used to represent the cycles of nature and the flow of life, a model of holistic living that Martin describes as having to do with "the balance between all things, the interconnections, the overlap."

The Medicine Wheel is generally represented as a flat circle marked in quarters relating to the four directions, but the wheel isn't flat. It's a globe embracing seven directions, including *Sky, Earth and Center*.

Martin's particular approach to working with the Medicine Wheel draws from Cheyenne, Crow and Lakota Sioux traditions. Many of the men who developed it are serving life sentences in the Montana State Penitentiary at Deer Lodge. With Chippewa-Cree heritage and roots in the Rocky Boy reservation, Martin stresses that his use of the Medicine Wheel "by no means speaks for all tribes. Caucasians tend to lump Indians together, but each tribe has its own thing."

In Martin's work, the Medicine Wheel offers a basis for a personal assessment based on developing a solid relationship with the 7th direction, the center of the globe. This is the direction where a person's values and beliefs are held.

The Medicine Wheel asks people to look at their entire belief system. "It's good for a disenfranchised population," Martin says. "They already feel out of center." But you don't have to be disenfranchised for this model to work. "I had a client who was a police officer. He loved it."

Other Medicine Wheel-based models for recovery have been developed specifically for Native Americans. The system Martin uses is for all people. It goes beyond reworking the twelve steps of Alcoholic Anonymous, though it does interact with the 12 steps, and it formalizes the 10th step of AA that asks for a daily check in.

The Wheel defines seven aspects of life that must be honored in order to achieve health and sobriety. These seven aspects of living begin in the East with the Emotional. The South holds the Mental, the West, the Physical as it relates to our bodies. Martin describes the North as spiritual and as anything that takes us outside of ourselves—the relationship between us and other people. The Sky represents our relationship with a Higher Power, with Spirit. Below is Mother Earth, the things that tie us to the earth, the physical things that need to be done.

The 7th direction is the hardest one to measure. It's the exact center of the circle . . . Initially, drugs and alcohol are the quickest way to the center. Sex takes us there, so do power and control and anger. When we move outside the circle we do dumb stuff like overeating, misusing sex, kicking the dog. You can cause a lot of damage without drinking. It's not good enough today just to not use. Working the medicine wheel is a self-defined program. It's consecutive. Each piece that pulls you further from center builds on others.

You learn to let go of the idea of being out of balance. You're just further from the center. It's like a fish bowl—you can't just fill or drain one side or the other.

So if one dimension can pull me out of the center, one dimension can pull me back in. Something like taking good care of the physical, cleaning house, doing mundane chores. According to the Medicine Wheel, if you do the things you're supposed to do, step by step, you will do better. Doing the little things moves you back in the right direction.

—Jamie Martin

Continued on Page 12

Medicine Wheel & Recovery

Continued from Page 11

Martin teaches addicts to measure their degrees of separation from the center by using a charted wheel. "These guys write incredibly insightful things about themselves and what they do. I hear people in my treatment groups saying, *'I was outside my circle.'* Acting out is doing something that will take us away from the center."

Martin believes that "Clients are getting beat up more by their belief systems, thoughts and values, than anything else. Many people get stuck in a circle between the emotional and mental. They keep going back and forth between the two and never progress to Spirit. Addiction," Martin says, "is less about alcohol and drugs and more about the obsession. Until we get that fixed, we get stuck on the wheel."

He adds, "We need to develop a sense of being, the fact that 'we are' is more important than what we do. Addicts' histories will tell them that it's best for them to shut down; to live the life of the walking dead. The Medicine Wheel gives intuitive and fundamental respect to the individual. No matter where you are on the circle you can learn to give . . . This isn't just about dealing with an addiction problem. It's about dealing with everyday living problems."

Jamie Martin has been developing this approach for approximately two years and uses it as a primary treatment approach for his Level I outpatient treatment program. He has developed an interactive, multimedia presentation that he takes with him to these presentations. It is a compelling approach that connects well with his clientele of pre-release residents. He can be reached c/o BSB Chemical Dependency; 20 W Front St; Butte, Mt. 59701.

—Jenna Caplette is the Prevention Writer for Alcohol & Drug Services of Gallatin County. She can be reached through her website at: www.jennacaplette.com

Gratefully adapted from *The Medicine Wheel & Recovery,* originally printed by the *Montana Pioneer,* April 2004.

The term co-occurring disorders *describes two independent medical disorders that occur at the same time. Within the mental health and substance abuse fields, the term typically describes the simultaneous presence of a mental health and a substance use disorder. Terms that can be used interchangeably with co-occurring disorders are:*

— Dual Diagnosis

— Coexisting Disorders

— Double Jeopardy

— MICA - Mentally Ill, Chemically Abusing

Source: National Gains Center for People with Co-occurring Disorders in the Justice System

http://www.gainsctr.com/curriculum/juvenile/mod_02_B_02.htm

Prevention

Though scant research has been conducted on the prevention of co-occurring substance abuse disorders and mental disorders, the limited data available suggest that since some of the risk factors for mental and substance abuse disorders may be identical (e.g. low socioeconomic status, family conflict, exposure to violence), **programs designed to prevent one disorder may prevent or forestall development of the other.** This may be especially true for adolescents, for whom emotional and behavioral problems, social problems, and risky health behaviors often co-occur as an organized pattern of adolescent risk factors (Greenberg et al., 2000).

Children and adolescents already experiencing serious mental disorders are at heightened risk for substance abuse disorders. This suggests the existence of a "window of opportunity" in which it may be possible to prevent the development of co-occurring substance abuse disorders by intervening early (SAMHSA, 2000; Ziedonis, 1995). For these children and adolescents, comprehensive programs that are family-focused, culturally appropriate, and available on a long-term basis have been shown to reduce problems at school and with the juvenile justice system, increase family cohesion and effective parenting, and decrease substance use/abuse.

—SAMHSA *Report to Congress*: *http://alt.samhsa.gov/reports/congress2002/execsummary.htm#3*

One Man's Success:

An Integrated Approach to Treatment

by Kathryn Kelley, M.A., NCC, LPC

"When *Jerry is not drinking or smoking pot, he is so full of energy. He can get a hundred things done, work two jobs and still spend time with the children. But when he's smoking pot and drinking, all he does is lay around. He's verbally abusive. He doesn't go to work . . . he just watches TV all day. I'm ready to leave him if you can't make him stop."

*Allison had brought her husband to my office in hopes that I could help him overcome his addictions to marijuana and alcohol. He was slumped on the couch and looking off to the left. His eyes were filled with despair. I asked Allison if I could talk to Jerry alone, and said I'd invite her back in a few minutes. She willingly agreed and left us alone.

"Jerry, do you want to feel normal again?" I asked. His answer didn't surprise me.

"I've *never* felt normal," he said. "I don't know what normal is. I just know that if I don't drink or smoke some weed, I can't slow myself down and it feels like I'm going to explode inside. I have to drink just to stop the feeling that I'm going crazy."

This introduction immediately alerted me to a probable dual diagnosis and suggested that his substance abuse could be rising from the suffering he felt from his mental illness.

Accurate diagnosis is essential to properly treating co-occurring disorders.

I told Jerry that he might have an underlying condition that was making him feel that way, and said I thought there was something we could do so that he wouldn't have to suffer anymore. I said that it would take work and asked if he was willing.

Jerry sat up straight and looked me in the eye. "If I can feel normal and get my family back, I'll do whatever it takes."

So we began. Jerry provided an in-depth history and had a complete evaluation by a qualified psychiatrist. He was suffering from some significant post-traumatic stress and had experienced a pattern of extreme mood swings since the onset of the PTSD. We engaged his family's support in his recovery. Since alcohol and drug withdrawal can sometimes worsen psychiatric symptoms, we were careful to approach treatment in stages. We began by helping him identify his goals, thus learning the skills he would need to actively control his illness and focus on his successes.

Since Jerry had been battling his mental illness in secret for many years, it was important to reinforce his self-image through "Resource Development" a therapeutic technique used to strengthen the sense of self. After he felt strong enough, we began integrating substance abuse assistance with a comprehensive mental health approach. A number of techniques were used in Jerry's treatment, including cognitive-behavioral, Gestalt, deep relaxation and transpersonal therapeutic approaches. All were designed to support Jerry in his healing and recovery.

Relapse prevention is an important component in treating co-occurring disorders. Jerry also joined a recovery group that focused on the needs of those with co-occurring disorders. This was very effective in giving him support outside the family structure and therapeutic environment. This "safe place" had a direct impact on the choices he made and the moods he adopted, strengthening his positive relationships and helping him shed those that supported his negative behavior.

Allison became a key player in Jerry's recovery. She learned more about Jerry's disorder and encouraged him as his behavior began to improve. She had the courage to deal with her own issues of anger and resentment. After several months of therapy and abstinence, Allison and Jerry began to focus on common goals. Their nutrition and exercise routines began to shift and they found that Jerry's mood swings became much less severe with the reduction of sugar and caffeine and the introduction of stress reducers including aerobic and strength building exercise.

Mood cycles or difficult situations can make individuals more vulnerable to making poor choices and relying on the "old friend" of alcohol or other drugs. Traditional psychotherapy and substance abuse counseling coupled with innovative techniques can work very well. Long-term treatment and skills development certainly reinforce the likelihood of success. Jerry responded very well to treatment and learned to reduce the intensity of the triggers that could have led to relapse. I still see Jerry and Allison occasionally, and each time have been pleased to see that they continue to do very well.

*Names and profiles have been changed to protect client confidentiality.

—Kathryn Kelley is a nationally certified counselor and certified EMDR Specialist. She is the founder of the Kelley Institute of Integrative Therapy. She is currently in the process of moving from Oregon to Helena. For more information on the Kelley Institute of Integrative Therapy, visit the website at: www.kelleyinstitute.com.

—Typical mental health conditions common in co-occurring disorders include anxiety, depression, bi-polar disorder, schizophrenia, and PTSD.

—According to the National Alliance for the Mentally Ill (www.nami.org), the prevailing research confirms that integrated treatment for co-occurring disorders is much more effective than treating these illnesses separately.

Fetal Alcohol Syndrome

by John P. Johnson, M.D.

– FAS-affected individuals experience difficulty with family life, socialization, school performance and normal adult integration into work and community life.

Fetal Alcohol Syndrome is the most common identifiable and preventable cause of mental retardation in the nation [CDC, 1995]. Fetal alcohol related effects (now called Fetal Alcohol Spectrum Disorder) manifests with various learning, behavioral, social and emotional problems. Nationally and internationally, fetal alcohol syndrome occurs with a frequency of 0.5-3/1,000 births. The other effects are at least 10 times as common.

Fetal Alcohol Syndrome (FAS) is a well-defined condition resulting from prenatal exposure to significant amounts of alcohol. In the classic form of FAS, there is a recognizable facial phenotype of small eye openings, mid-face and upper lip abnormalities associated with central nervous system involvement and growth disturbances, including retardation of growth (height and head size) and intellectual development. The average IQ for classic FAS is about 65.

No amount of alcohol is safe during pregnancy.

Most alcohol-related prenatal damage does not result in classic FAS, but in less recognizable patterns that include minor anomalies. Some individuals have no visible abnormalities, and may even have normal intellectual ability. This is due to the wide variation in the dose and timing of the alcohol used (chronic heavy use as versus episodic binges), the vulnerability of the mother, and of the individual fetus.

Of major concern is the lack of recognition of the morbidity of the milder conditions that result from fetal alcohol exposure. Because of the variability of the underlying brain damage, patients—frequently with normal appearance—demonstrate a wide spectrum of behavioral and intellectual disability. They fail to function at expected levels, with adaptive function as low as 50 percent of that predicted by standard testing [Shaywitz et al., 1980; Streissguth et al., 1991; 1994].

FAS-affected individuals experience difficulty with family life, socialization, school performance, and normal adult integration into work and community life. In addition, the majority are not raised in their biological homes and experience multiple foster placements and other environmental psychosocial stressors. Distractibility, inability to plan and execute sequential and, in particular, open-ended activities, as well as inability to perceive social cues, predict consequences or control impulsivity underlie much of their dysfunction. Because of this, they almost invariably become clients of a variety of medical, social, educational, behavioral and legal services.

The reason for these problems is not always apparent, and coordination among the agencies involved may be less than optimum. It is ironic that individuals who do receive good preventive services are often "punished" for good care, by losing eligibility for Social Security Disability payments or being discharged from group homes. This results from a lack of recognition that disability associated with FAS is lifelong. These individuals usually fail at independent living. They often drop out of school, wind up in jail, unemployed or homeless. Often they are mentally ill. Alcoholism, partly related to familial predisposition, and criminal behavior related to poor judgment and gullibility are common. These problems are often described as *secondary disabilities,* and occur in a very high percentage of individuals who have not received early-intervention.

Fetal alcohol spectrum disorder is an expensive condition. The estimated cost varies widely depending on many factors, including severity of the condition. There are no estimates of the cost of anything less than full FAS, but a congressional estimate made in 1998 placed the national cost at $2.8 billion per year.

—John P. Johnson has been the Medical Director of the Genetics Program since 1994. He is board-certified in pediatrics, clinical genetics and molecular genetics.

About Shodair

Shodair Hospital is a specialized children's hospital, providing psychiatric and genetics services. Shodair Children's Hospital continues to grow and expand its services to the children and adolescents in Montana who suffer from emotional, mental, and behavioral problems. The psychiatric unit now has four treatment programs—the acute unit, the children's unit, and two adolescent units.

Shodair Hospital and its statewide satellite clinics see approximately 100-200 children and adults annually to evaluate for or follow up on a diagnosis of FASD. Evaluation includes diagnosis and recommendations for intervention. Follow-up includes discussion of progress—socially, academically, and within the family, as well as education, including written materials, web resources and appropriate referrals.

For more information, visit:
www.shodair hospital.org/

Secondary Conditions and FAS

Secondary conditions are problems that a person is not born with, but might acquire as a result of Fetal Alcohol Syndrome (FAS). These conditions can be lessened or prevented through better understanding of and appropriate interventions for children and adults with FAS and their families. Following are some of the secondary conditions commonly associated with FAS.

Alcohol and Drug Problems—Studies suggest that more than a third of individuals with FAS have had problems with alcohol or drugs, with more than half requiring inpatient treatment.

Mental health disorders—Several studies have shown an increased risk for cognitive disorders, psychiatric illness, or psychological dysfunction among individuals with FAS. The most frequently diagnosed include Attention-Deficit/Hyperactivity Disorder (ADHD), conduct disorder, alcohol or drug dependence, depression or psychotic episodes. Anxiety disorders, depression, eating disorders and posttraumatic stress disorder have also been reported among some patients with FAS.

Disrupted school experience—Children with FAS are more likely than most children to be suspended, expelled or to drop out of school. They often have difficulty getting along with their peers and teachers and may have issues with truancy. Many children with FAS remain in school but have negative experiences because of their behavioral challenges.

Trouble with the law—Teenagers and adults with FAS are more likely to have interactions with police, authorities or the judicial system. Difficulty controlling anger and frustration combined with difficulty in understanding others' motives often results in violent or explosive situations. People with FAS can be easy to persuade and manipulate, which can lead to their inadvertent participation in illegal acts.

Inappropriate sexual behavior—Individuals with FAS are more likely to exhibit inappropriate sexual behavior, such as inappropriate advances and inappropriate touching. Being a victim of violence increases the risk of participating in sexually inappropriate behavior.

Dependent living and problems with employment—Adults with FAS generally have difficulty sustaining employment or living independently.

Problem parenting—Individuals with FAS may have poor judgment and poor impulse control as a result of primary brain dysfunction. These factors, combined with a secondary condition of alcohol dependence, can result in unprotected sex and pregnancy. This can possibly lead to another generation at risk of prenatal alcohol exposure. Individuals with FAS who become parents are more likely to have histories that include unstable homes, homelessness, runaway and domestic violence as compared to individuals with FAS who do not become parents.

Source:

From: Streissguth, A.P., Barr, H.M., Kogan, J. & Bookstein, F. L., "Understanding the Occurrence of Secondary Disabilities in Clients with Fetal Alcohol Syndrome and Fetal Alcohol Effects," Final Report to the Centers for Disease Control and Prevention (CDC), August, 1996.

www.cdc.gov/ncbddd/fas/secondary.htm

The Facts about FAS

- *FASD (Fetal Alcohol Spectrum Disorders) is the leading known preventable cause of mental retardation and birth defects.*
- *FASD affects 1 in 100 live births or as many as 40,000 infants each year.*
- *An individual with fetal alcohol syndrome can incur a lifetime health cost of over $800,000*
- *In 2003, fetal alcohol syndrome cost the United States $5.4 billion—direct costs of $3.9 billion, and in-direct costs of another $1.5 billion.*
- *Children do not outgrow FASD. The physical and behavioral problems last a lifetime.*
- *FAS and FASD are found in all racial and socioeconomic groups.*
- *Women with FAS or affected by FASD have healthy babies if they do not drink alcohol during their pregnancy.*

Source: National Organization on Fetal Alcohol Syndrome. www.nofas.org/faqs.aspx

—If a child was exposed to alcohol during pregnancy, but does not have all of the symptoms of FAS, he or she may have alcohol-related neurodevelopmental disorder (ARND). Children with ARND may demonstrate learning and behavioral problems similar to those experienced by children with FAS.

—One CDC-sponsored study found that children with FAS and ARND are at very high risk for developing secondary conditions such as difficulties in school, trouble with the law, alcohol and drug abuse problems, and mental health disorders.

Welcome to the New Director!

Born in Plentywood, Montana to farmer parents, Bob Wynia graduated from Poplar High School, went to Eastern Montana College in Billings, then to the University of Washington, where he was admitted to the School of Medicine as a nonresident medical student. After graduation, he applied to the University of Michigan Hospital as an intern. He planned to become a surgeon, but soon realized that he found diagnostics more interesting. This led to a 42-year practice as a primary care physician in Great Falls, with his wife, Winona, serving as nurse, receptionist and bookkeeper.

Dr. Bob has had a lively, career-long interest in health care administration. He's been involved in the Montana Medical Association, the American Medical Association and served as State Chair for the Organized Medical Staff of the AMA until the end of 2004. In 2002, he began limiting his practice, then discontinued active clinical practice at the end of 2004. Soon after, he started looking for new career opportunities, but reports that he hadn't found the right challenge until he received a call from Governor Schweitzer's transition team, asking if he might consider directing DPHHS.

We wish him all the best of luck!

A Note from the Director

As the new director of DPHHS, I want you to know how happy I am to be a part of your "family." I am enjoying the challenge. That's because the more I learn, the more I realize how good this department is—because of each of you and because of the great administrators here. Please know that my door is always open. I welcome and appreciate your help and your suggestions. Thank you for the good work you've been doing and, I hope, will continue to do.
—Dr. Bob Wynia (a.k.a. Dr. Bob)

We Know What's Wrong, Now What Do We Do?

The Intermountain Children's Home & Services Approach

by Elizabeth Kohlstaedt, Ph.D.

The single most important quality in raising a securely attached child is the parents' ability to understand and examine themselves.

Chronic Trauma and Attachment Disturbance

What happens to children who have the worst of all circumstances . . . starting with an abusive or neglectful mother, a chaotic environment that includes routine physical harm or the threat of harm, followed by removal and loss of the parent for the child's safety . . . then movement through multiple environments as the child's behavior goes out of control? The combination of disorganized attachment, unresolved loss and trauma, and instability of placement is an all-too-common scenario of children in foster care.

A child who survives a scenario like the one described above perceives just about all events as threatening, and acts aggressively to ward off that threat. This child is often controlling, bullying and sexually and physically aggressive with other children. Each time this child experiences the need for closeness (when he's lonely, scared, sick or tired), he experiences tremendous anxiety as that need was met by abuse and danger in his original relationship. He might freeze, strike out at the adult, rage and cry. If this child hears a simple *no*, he may react from his brainstem and throw a chair or attempt to bite or hurt the adult who denied him. This child might feel justified in killing the cat that bit him or setting fire to the home of the adult who told him he couldn't watch cartoons. This is the child who sneaks into his sibling's bedroom to have sex, hoards food, or urinates in the hallway to mark his territory.

Over the past 10 years, there has been an explosion of research on the importance, durability and behavioral effects of attachment security (Cassidy and Shaver, 1999) and the long-lasting physical and emotional effects of early loss and trauma (Perry, 1995). From this research, it is clear that the relationship between mother and infant within the child's first two years of life acts as the internal working model for all future relationships. Chronic trauma within the first two years of life permanently alters the reactivity of certain brain structures, including the brain stem, amygdala, and hypothalamic-pituitary-adrenal axis. The result is an alteration of the child's perception of and reaction to events throughout life. (Perry & Pollard, 1998; Schore, 2003; Siegel, 1999).

Disorganized attachment occurs when parental behavior is a source of disorientation or terror. When children's experiences with their parents leave them overwhelmed, traumatized, and frightened, youngsters develop disorganized attachments, which lead to difficulties with regulating emotions, social communication and academic reasoning as well as to severe emotional problems.

In distress, most children turn to a parental figure. The predicament that rises from disturbed attachments and emotional and physical trauma is children are rendered unable to use the very relationships they need to feel safe—these children cannot perceive even a safe adult as a secure base. Children with disturbed attachments experience further disorganization and fright during periods of distress. Even in foster or adoptive parenting relationships, they impose their internal models onto the new parents and become disorganized whenever experiencing the need for closeness. As the child overlays his old relationship onto the new one, he may perceive the foster parents as abusive and frightening. As the treatment parents attach, the child often evokes disquieting responses such as rage, frustration and impotence.

Continued on Page 17

Now what do we do?

Continued from Page 16

Outpatient psychotherapy that attempts to uncover and resolve a child's trauma and loss only disorganizes the child further, further threatening the fragile new relationship. Medication that typically helps less disturbed children at best helps only briefly. More often, it makes the child more agitated, sexual and oppositional. The first step in healing is to stabilize the child within a parenting relationship. If the child is too disturbed, or if the parents are too frightened or exhausted, this can mean out-of-home treatment.

***Parenting from the Inside Out: How a deeper self-understanding can help you raise children who thrive* by D. Siegel & M. Hartzell (2003) is an excellent resource.**

Intermountain Children's Home and Services provides residential treatment for children who require out-of-home treatment. Through our developmental/relational approach, treatment staff becomes the attachment figure for the child. The new attachment does not replace the pathological one, but stands alongside the old one as a new way of relating. Treatment staff must be able to safely contain behavior, then discern the need beneath the behavior . . . bring the child close when wild, primitive feelings take over. Treatment staff helps the child translate violent behavior into more adaptive expressions of feelings, to tolerate anxiety and to talk to an adult when frightened.

Treatment staff must be responsive, psychologically available, and able to examine their own motivations and reactions. They must also be able to have spontaneous fun and adventure with the child, helping him develop an identity beyond *the bad kid no one wanted.* Once the relationship has been formed, the child can use therapy to talk about and make sense of his fractured life—to see his role and his parents' roles realistically. This re-education in living takes about two years.

If the child can remain in the family, the parents' anxiety and despair must be addressed so that they have enough psychological calm to calm the child. Dan Siegel pointed out that the single most important quality in raising a securely attached child is the parents' ability to understand and examine themselves (Siegel & Hartzell, 2003). Treatment staff must be able to bring distressed parents close, help them examine their reactions to the children and help them fulfill their desire to be healing parent. The child needs help to talk about distress to the parents; parents need help to discern the child's need beneath the inexplicable behavior. Once the child feels safe within the relationship, therapy that includes the parent can help the child resolve past losses and traumas.

—Elizabeth Kohlstaedt, Ph.D., is a licensed psychologist and has been the Clinical Director of Intermountain Children's Home and Services for the past 15 years. Dr. Kohlstaedt received a BA in German from Purdue University, an MS in linguistics from Indiana University, an MA in physiological psychology from Arizona State University and a Ph.D. in clinical psychology from University of Montana. Dr. Kohlstaedt has appeared on Prime Time Live, National Public Radio and in the Los Angeles Times to discuss attachment disorders and has done training throughout the nation.

Additional Resources

Handbook of Attachment: Theory, Research and Clinical Applications. *Cassidy, J. & Shaver, P., Editors (1999). New York:Guilford Press.*

Maltreated Children: Experience, Brain Development and the Next Generation. *Perry, B. (1995). New York: Basic Books*

Healing Trauma: Attachment, Mind, Body and Brain. *Schore, A. Solomon, M., & Siegel, D., Editors (2003). WW. Norton & Co: New York.*

The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are. *Siegel, D. (1999). New York: Guilford Press.*

Intermountain Children's Home and Services uses relationships to treat moderately to severely emotionally disturbed children. The children served have unstable or disordered attachments to their primary caretakers as well as emotional and behavioral difficulties in other relationships. Outpatient therapy alone has not been sufficient to treat these children, who need stable adults to enhance their trust of adult care and control through support, redirection and structure. ICH uses a developmental/relational approach to help children form healthy attachments from which to resolve trauma and loss.

Principles include:

1. *Close, personal and intense relationships help children build the capacity for intimacy and belonging.*
2. *Psychological and physical strengths and potential should be emphasized.*
3. *Life should be gratifying.*
4. *Treatment should be a re-education in living.*
5. *Supportive control is the most effective means of making a child feel safe and risk engaging in a relationship and changing.*
6. *Physical and emotional nurturance is a child's right.*

For more information, visit www.intermountain.org

Disability Determination Services

by Michelle Thibodeau

President Roosevelt signed the Social Security Act into law on August 14, 1935. On August 1, 1956, the Social Security Act was amended to provide monthly benefits to workers aged 50 to 64 who were permanently and totally disabled and for adult children of deceased or retired workers, if disabled before age 18.

From these beginnings have come the much expanded disability benefits programs: Social Security Disability Insurance (SSDI) program, which is based on prior work under Social Security, and Supplemental Security Income (SSI) program, which is based on financial need.

Total security is not possible. However in the words of Wilbur J. Cohen, the first professional employee of Social Security, "There is a moral justification for a safety net . . . a consciousness of community that provides a program to assist those members of the community who are in medical and financial need due to an illness or injury that prevents their wage earners."

Today, more than three million people nationwide apply for SSDI or SSI each year; the Social Security Administration (SSA) makes monthly payments to more than nine million disabled individuals and their families. These programs provide cash payments and health care coverage when a worker or eligible individual is unable to work for at lest a year due to a physical or mental impairment.

Disability claims are processed through a network of about 1,300 SSA field offices, 8 Regional Offices and 54 state agencies known as Disability Determination Services (DDS). The DDSs are fully funded by the Federal Government, and are responsible for developing medical evidence sufficient to render an equitable determination on whether the claimant is or is not disabled or blind under the law, and to determine when disability began.

The DDS obtains medical evidence from the sources the claimant lists on the application. If the evidence is insufficient to render a decision, the DDS will purchase an examination from the treating source physician or another independent provider. Once the case is complete, the adjudication team comprised of a physician and/or psychologist and the adjudication officer render a decision.

The DDS process is designed to achieve the highest degree of accuracy, uniformity, consistency and timeliness. It relies on the participation of the medical community, both in providing the medical evidence used in determining disability and in the actual process. To ensure uniformity and consistency in the way DDSs make decisions, SSA developed a five-step process called *sequential evaluation*. The DDS must adjudicate the claimant's remaining ability to function while considering age, education and work history. The DDSs also use set of medical evaluation criteria for all body systems known as the Listings. The DDS reviews those receiving disability benefits on a systematic schedule ranging from one to seven years.

If you would like more information on disability programs please contact Michelle Thibodeau with the Montana DDS at 406-444-3054 or michelle.thibodeau @ssa.gov

---

An individual with a mental disorder, such as depression, is at increased risk for developing a substance abuse disorder and, conversely, a person with a substance abuse disorder is at increased risk for developing a mental disorder.

Source: Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders, *Substance Abuse and Mental Health Services Administration, 2002.*

Tools for Schools

by Kirk Astroth, Ph.D.

Addiction to methamphetamine carries with it a high risk of developing a range of severe, long-term effects. Meth use can cause depression, anxiety, mood changes, paranoia and other psychological disorders that create dire consequences for users. Moreover, meth use causes extreme physical and cognitive deterioration. There are *no* short-term or long-term benefits to using meth. There are only damages.

It's no secret that methamphetamine use is a serious problem in Montana. It is a statewide issue that affects everyone, regardless of personal use or direct involvement. Especially during adolescence, youth are making decisions that will affect the rest of their lives. Peer pressure and the desire to fit in—among a multitude of other risk factors—can lead to high risk behaviors including drug use. To compound an already confusing time, methamphetamine—deadly and highly addictive—has become widely available across our state, as it has in many other states.

A successful effort to reduce meth use in the state must be based on a multi-faceted statewide campaign that includes prevention, intervention, treatment and aftercare. Many efforts have been put into place to combat the production and use of methamphetamine among adolescents, but prevention remains key. As just one example of the state's focus on prevention, Montana State University—Bozeman has been awarded a grant by the Montana Office of Public Instruction (OPI). The MSU Meth Education Partnership is charged with developing educational tools for middle- and high-school teachers to use in their

Continued on Page 19

Tools for Schools

Continued from Page 18

classrooms. State Superintendent of Schools Linda McCulloch and Attorney General Mike McGrath announced the new pilot program in October 2004.

> —*" . . . the effects of methamphetamine use do not stop at the school house doors. The costs to our children and communities are enormous. Not only in terms of the human tragedy of those who use this incredibly addictive drug, but the disruption of children's lives coming from families which use meth."* —Superintendent of Public Instruction, Linda McCulloch.
>
> —*"The costs of methamphetamine use in Montana are staggering and they will continue grow unless we can keep young Montanans from using meth in the first place. This partnership with the Office of Public Instruction and these materials will be important resources for prevention."* — Attorney General Mike McGrath

The new *Tools for Schools Program* will help expand the skills and tools available to local educators who want to educate students about the dangers of meth. Under the leadership of Dr. Kirk Astroth of the Montana 4-H Center for Youth Development, a team will use the grant to provide teachers with tools to help them combat the use of methamphetamine among their students. Ultimately, the students will have the opportunity to learn about the effects on Montana's communities and ways to tell if a friend or family member is involved in manufacturing or use of the drug. The goals of the project include:

- — Providing high-quality educational PowerPoint resources for middle- and high-school and community youth groups;
- — Facilitating public awareness through a series of community forums and conference presentations; and
- — Offering technical assistance to the OPI methamphetamine drug awareness project.

The *Tools for Schools* materials will be co-packaged with other meth prevention materials that are part of a broader community tool kit. This kit will include educational materials, brochures, posters, video tapes and other resources for realtors, landlords, retailers and merchants, and a host of other community members who need to be enlisted in the fight against the proliferation of meth use, manufacture and distribution. The kit will also include *MethWatch* materials.

In addition to Astroth, development team members include Mike Vogel, Housing and Energy Specialist; Lynn Paul, Nutrition Specialist; Sandy Bailey, Family and Human Development Specialist; Jeff Linkenbach and Gary Lande of the MSU Social Norms Project. Together, the team will create PowerPoint presentations that provide basic information about the drug and a look into a future with—and without—meth. There will be information on Montana's efforts with MethWatch, impacts of meth on the community, family and friendship dynamics. Additional information on self-image—dieting, body image and self-esteem will showcase pathways to health.

These PowerPoint presentations will be distributed to educators around the state and promoted through three educational, statewide conferences. The PowerPoint presentations come complete with a teacher outline, tips for effective presentation, and supplemental activities to use in addition to the PowerPoints. More than 900 schools and all MSU County Extension Offices will receive copies. Additionally, anti-meth materials will be available publicly so that other youth-serving organizations can learn how to incorporate them into their respective programs. Interestingly, other states have already expressed interest in the draft materials and are asking how to purchase copies once they are completed.

Meth prevention materials are currently being designed and are scheduled for release in June 2005. For more information, contact Dr. Kirk Astroth at kastroth@montana.edu or 406-994-5691.

Co-occurring Effects of Meth

Methamphetamine is highly addictive, and users develop tolerance quickly, needing larger amounts to get high. In some cases, users forego food and sleep and take more meth every few hours for days, binging until they run out of the drug or become too disorganized to continue. Chronic use can cause paranoia, hallucinations, repetitive behavior (such as compulsively cleaning, grooming or disassembling and assembling objects), and delusions of parasites or insects crawling under the skin. Users can obsessively scratch their skin to get rid of these imagined insects. Long-term use, high dosages, or both can bring on full-blown toxic psychosis (often exhibited as violent, aggressive behavior). This violent, aggressive behavior is usually coupled with extreme paranoia.

Source: www.drugfree.org/Intervention/Drug_Guide/Methamphetamine

Want to Know More?
A Few Great Resources

Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders (2002)

The human, social, and economic costs of co-occurring substance abuse disorders and the continuum of mental disorders take a toll on the individual experiencing them, the family, the school, the workplace, the community, the State and, ultimately, the Nation as a whole.

This report includes:

— a summary of current treatment, including up-to-date information on the number of children and adults with co-occurring disorders;

— a summary of practices for preventing substance abuse disorders among individuals who have a mental illness and are at risk of having or acquiring a substance abuse disorder;

— a summary of evidence-based practices for treating individuals with co-occurring disorders and recommendations for implementing such practices; and

— a summary of improvements necessary to ensure that individuals with co-occurring disorders receive the services they need.

Access this very comprehensive and readable report on-line at:
alt.samhsa.gov/reports/congress2002/index.html

CCISC: *Comprehensive, Continuous, Integrated System of Care*

This model helps providers organize services for individuals with co-occurring psychiatric and substance disorders, and is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states, to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies. The model has the following four basic characteristics:

1. **System Level Change:** The CCISC model is designed for implementation throughout an entire system of care, not just for implementation of individual program or training initiatives. Implementation of the model integrates the use of system change technology with clinical practice technology at the system level, program level, clinical practice level, and clinician competency level to create comprehensive system change.
2. **Efficient Use of Existing Resources**: The CCISC model is designed for implementation within the context of current service resources, however scarce, and emphasizes strategies to improve services for clients who have co-occurring disorders within the context of each funding stream, program contract, or service code, rather than requiring blending or braiding of funding streams or duplication of services. It provides a template for planning how to obtain and utilize additional resources should they become available, but does not require additional resources, other than resources for planning, technical assistance and training.
3. **Incorporation of Best Practices**: The CCISC model is recognized by SAMHSA as a best practice for systems implementation for treatment of co-occuring disorders. An important aspect of CCISC implementation is the incorporation of evidence based and clinical consensus-based best practices for the treatment of all types of co-occurring disorders throughout the service system.
4. **Integrated Treatment Philosophy**: The CCISC model is based on implementation of principles of successful treatment intervention derived from available research and incorporated into an integrated treatment philosophy that utilizes a common language that makes sense from the perspective of both mental health and substance disorder treatment professionals.

Dr. Kenneth Minkoff is credited with the development of the CCISC Model, which was referenced in SAMHSA's Report to Congress on Co-occurring Disorders (2002). Dr. Minkoff and his associate, Dr. Christie A. Cline, have been working in Montana to guide progress toward a co-occurring capable system of care. For more information, visit Dr. Minkoff's website at: www.kenminkoff.com/index.html

Blamed and Ashamed

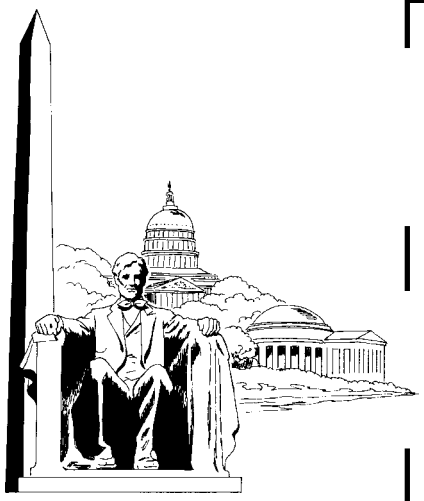
Co-occurring substance abuse and mental health disorders are inseparable problems and cannot be effectively addressed in isolation. The current categorical distinctions reflected in the funding streams and administrative structures for physical and mental health services, substance abuse services, social and family services, educational services and legal services have prevented youth and their families from obtaining the kind of comprehensive and integrated treatment they need. Complex physical, psychological, social, economic and environmental factors contribute to the substance abuse among youth with mental health problems. All these factors must be considered in order to individually design treatments, services, and supports that will be effective for any particular young person and his or her family.

—Blamed and Ashamed: The Treatment Experiences of Youth With Co-occurring Substance Abuse and Mental Health Disorders and Their Families, www.mentalhealth.samhsa.gov/publications/allpubs/KEN02-0129/conclusions.asp

The DC Connection

by Theresa Racicot

—We can be justifiably proud of our many accomplishments in exploring the outer reaches of space. Our nation has been—and continues to be—a leader in this unknown realm. Finding better ways of treating diseases and multiple co-occurring conditions, of understanding the connections between body and mind, are also unknown realms that need exploration.



Reading horror stories in the newspaper or hearing accounts of people abusing or binging on alcohol raises the question of whether the problem is more than just the use of the alcohol itself. Often, alcohol is used as a form of self medication . . . to mask pain and psychological hurt. Once the two are intertwined, it makes it even more difficult to deal with underlying problems.

While much of past research has focused on treatment for patients with a single diagnosis of alcohol abuse or dependence rather than on patients with a co-occurring disorders, an important shift is taking place. Reality is setting in. Increasingly scientists are looking at the relationship between mood disorders and substance use and abuse. Clinical studies at the community level reveal high rates of mood disorders—including major depression and bipolar disorder, two name just two—among people diagnosed as alcohol dependent. The National Comorbidity Survey (1996) found that psychiatric disorders usually began about 10 years earlier than the start of the addictive disorder. The exception to this order of onset was that 72 percent of alcohol-abusing males reported that their alcohol abuse began before the onset of a mood disorder.

Co-occurring . . . dual diagnosis . . . co-morbidity . . . no matter what it is called, it presents huge treatment challenges. What do you treat first? How does a physician diagnose or treat multiple co-occurring disorders, when single psychiatric disorders are difficult enough to treat in and of themselves. The relationship between depression and alcoholism is complex because of overlapping symptoms, common neurobiological abnormalities and similar treatments. It is a challenge for the physician, the health care system, and for the family members trying to understand how best to ensure that a loved one receives the best care.

Mental health and substance abuse facilities are expanding services for patients with co-occurring disorders, integrating psychiatric and substance abuse treatments, and seeking broader education and training for the professionals who staff these facilities. Because acute psychological problems undermine a person's ability to participate in his/her own treatment, stabilizing these symptoms is usually the first priority in treatment. This is followed by integrating services that address both substance abuse and mental health problems.

Integration is critical for a number of reasons:

(1) early intervention may reduce the severity of both disorders;

(2) improves the treatment outcomes; and

(3) reduces health care costs.

All are compelling and life-saving reasons for the health care system to recognize and commit to treating co-occurring diseases and health problems. It is also critical that states continue to invest in supporting such services.

10 Critical Components of a Good Prevention Program

1. *Research based, theory driven.*
2. *Effective programs offer developmentally appropriate information. Teens tend to be more interested in the here and now than in potential future effects. Information about short-term negative social consequences of use should be a primary ingredient.*
3. *The most effective programs teach social resistance skills (how to say* no*). Especially at the junior high level, these programs help teens learn to resist peer pressure.*
4. *Normative education. Teens learn that most people* do not *use drugs and alcohol.*
5. *Personal and social skills training. Teens need problem-solving skills as well as goal-setting, stress management, and communication skills. Building these skills actually leads to reductions in drug and alcohol use among teens.*
6. *Interactive teaching techniques.*
7. *Teacher training and support, with emphasis on using interactive teaching strategies in addition to covering the facts about drugs and alcohol.*
8. *In-depth interventions and booster sessions. A one-shot program has little likelihood of success.*
9. *Culturally sensitive.*
10. *Outreach.*

Teacher Talk: Volume 3, Number 3. Indiana University - The Center for Adolescent Studies. www.drugstats.org/tt/v3i3/building.html

Pulling Together

by Bill Slaughter, Director, Department of Corrections

When Governor Schweitzer named Dr. Wynia and me to his Cabinet, he told us that he expected us to work together so closely that we'd feel as if we were joined at the hip. He's right to expect that. We share a common client base, and pulling together is the best way to meet the needs of Montana.

Montana continues to experience a 4–5 percent annual growth in its prison population, but the faces of the crimes we're seeing have changed dramatically over the years. For one thing, there's been a decline in violent crime coupled with a huge increase in drug- and alcohol-related offenses.

The top five crimes for men in the multi-year period from 1995–2004 were theft, possession of drugs, burglary, felony DUI and sale of drugs. For women, it was possession, theft, forgery, issuing a bad check over $150, and sale of drugs. It's safe to assume that thefts, burglaries, bad check charges and sale of drugs are all connected to addiction, with methamphetamine the recent drug of choice.

Currently, the Department of Corrections has nearly 200 women in prison. Nearly all (85%) are nonviolent offenders. While it's true that the Department of Corrections must maintain prison beds for truly dangerous and predatory offenders, at a cost of $80 a day per offender, prison is probably not the most effective—nor the cheapest—way to help people deal with addiction.

Truthfully, the nonviolent offenders—male and female—who wind up in our prison system have had to work hard to get there. They've been given chance after chance to avoid prison and to turn their lives around, but at some point, their chances ran out and they were revoked to prison. Typically, it's because they cannot avoid drugs and alcohol in a less restrictive environment. About 47 percent of all adults currently in prison are there because they could not maintain clear conduct and alcohol/drug free urinalyses.

In the past, social service providers and corrections professionals viewed the people they served as distinct, separate pools. There were "our people" and "those people of yours." We have undergone a paradigm shift, not only here at Corrections, but throughout the ranks of the Department of Public Health and Human Services. What we've come to realize is that they're *all* "our people."

Approximately 16 percent of the prisoners in the corrections system are mentally ill. Statistics reveal that the mentally ill are more likely than other offenders to have committed a violent offense. They typically have longer criminal histories and are incarcerated for longer periods of time than inmates without mental illness who commit similar offenses. In recognition of this issue, a coalition called *Building Bridges* was formed a year or so ago. Its purpose is to focus on mentally ill prisoners discharged from state prisons. In the past, these people would often run out of medication and money long before they could access benefits. The result was recidivism. We're working hard to end the cycle that leads from prison to crisis and back to prison again.

Before she left, Gail Gray and I signed a Memorandum of Understanding (MOU), to ensure the continuation of the *Bridges Coalition* and other efforts we'd started. By signing that MOU, we formally acknowledged that we share common clients—and that we need to work together to help those clients achieve the best possible outcomes. Dr. Wynia has expressed his complete support for our continued collaboration.

Our goal is to begin looking at addressing the needs of the *whole person*, which means ensuring that corrections staff have the training they need to recognize and address mental illness and other underlying issues that bring people to our doors in the first place. There's no doubt that the corrections system in Montana faces some tough challenges. We need to train new probation officers, grow community programs that promote job development and skill-building. And we need to ensure access to drug and alcohol counseling and treatment. Ultimately, this means that we need to cooperate with the agencies working with the offender population—first and foremost, the Department of Health and Human Services. We look forward to building more bridges between our departments. It's the right thing to do for the clients we share, for their families . . . and for Montana.

Turning Lives Around

During Fiscal 2002, ***22%*** *of the populations at Montana State Prison (287) and at Montana Women's Prison(16) were employed by Montana Correctional Enterprises.*

At Montana State Prison:

*— **97** inmates passed the GED,*

*— **350** completed Chemical Dependency Treatment, and*

*— **125** completed Anger Management.*

*Within 90 days of admission, juveniles at Pine Hills Youth Correctional Facility raised their Reading Comprehension **1.2** grade levels, their Language Expression **2** grade levels, and their Math Computation **1.1** grade levels.*

Community Service and Restitution

During FY 2002, among Pine Hills Youth Correctional Facility youth:

*— **46** participated in restitution programs;*

*— **66** participated in community service programs*

*— residents paid **$28,560** in restitution to victims.*

Residents of Riverside Youth Correctional Facility:

*— completed **590** hours of Community Service.*

*Probationers and Parolees made **$1,827,638** in restitution payments.*

For more information, visit: www.cor.state.mt.us

A huge percentage of the people we serve through the corrections system have issues with addiction. Many— if not most—have co-occurring mental health disorders. Almost no one is there for just one issue, and many also have physical health problems as well. **—Bill Slaughter**

Treating Co-occurring Disorders

***Individuals with co-occurring disorders should be the expectation, not the exception, in the substance abuse treatment and mental health service systems. Unfortunately, there continue to be many barriers to appropriate treatment and support services.* —SAMHSA Administrator Charles G. Curie**

People with co-occurring serious mental illness and substance abuse often do not recognize that they need treatment, according to data from SAMHSA's annual National Survey on Drug Use and Health (2002). The data show that 61 percent of those with both serious mental illness and a substance use disorder had not received treatment for either illness—nor had they perceived unmet need for treatment.

The data also show that more than half (52 percent) of the 4 million adults age 18 and older with co-occurring serious mental illness and a substance use disorder received neither mental health nor specialty substance use treatment during the past year. An estimated 34 percent received only treatment for mental disorders, 2 percent only received specialty substance abuse treatment, and close to 12 percent received treatment for both mental and substance use disorders.

Analysis of the data also shows that adults with a substance use disorder in 2002 were almost three times as likely to have serious mental illness (20.4 percent) as those who did not have a substance use disorder (7.0 percent). The rate of serious mental illness was 19.0 percent among those with alcohol dependence or abuse, 29.1 percent among those with illicit drug dependence or abuse, and highest among adults who had both drug and alcohol dependence or abuse (30.1 percent).

Two recent SAMHSA publications discuss these findings in depth. *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders, 2002,* is a 132-page report based on analysis of the 2002 NSDUH data. *Adults with Co-Occurring Serious Mental Illness and a Substance Use Disorder* is part of a series of short reports on selected topics published by SAMHSA. Electronic versions are available online at *www.oas.samhsa.gov*.

Barriers to Integrated Care

— Separate and uncoordinated systems
— Separate funding streams
— Lack of cross-training
— Philosophical differences
— Conflicting regulations

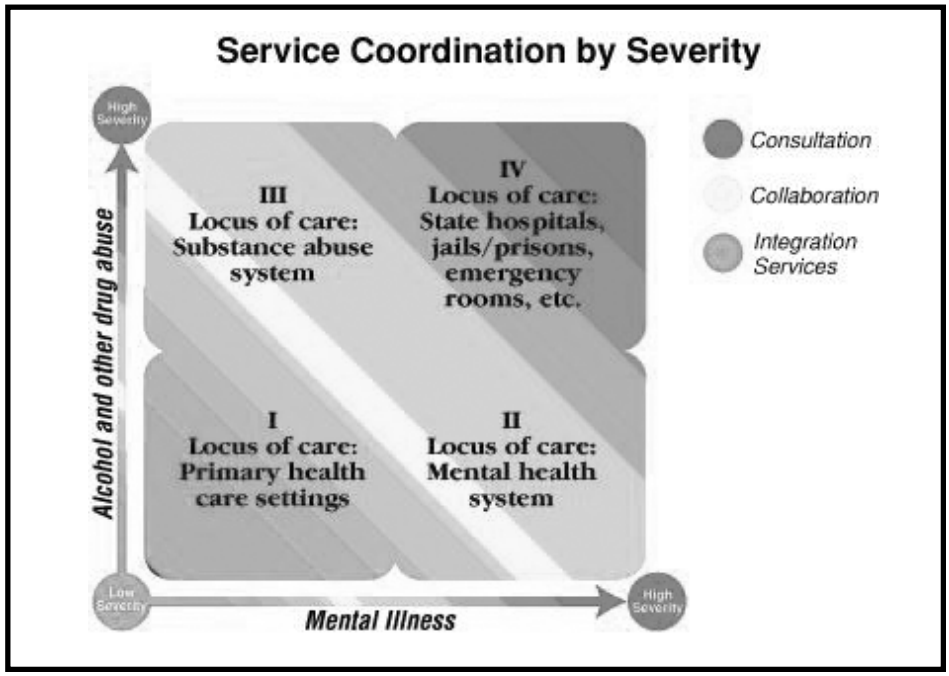
Mental and behavioral disorders such as depression, substance and alcohol use, self-inflicted injury and death, and similar problems play an enormous role in the global burden of disease. "Substance abuse and mental illnesses account for almost 40 percent of the disability in the developed world," says NIMH Deputy Director Richard Nakamura, Ph.D.

The Matrix

A conceptual matrix now widely used by states focuses on mental illness and substance abuse. The four quadrants of the matrix help conceptualize levels of severity and the primary focus of treatment for co-occurring disorders. It also shows how the mental health and substance abuse systems can work together to address the needs of this population. For example, treatment for those with high-severity addiction and low-severity mental illness could be based in the addiction system with consultation from mental health. Those with combined high severities of both disorders would need specialized treatment with cross-trained staff, expert on both conditions.

Co-occurring conditions such as HIV/AIDS, hepatitis, or any of the other physical ailments that often accompany mental illness and substance abuse compound the problem. People with psychotic disorders, substance use disorders, or both have higher rates of medical problems like heart disease and asthma than those without mental health conditions. They're also less likely to get optimal care or adhere to treatment regimens.

http://alt.samhsa.gov/samhsa_news/VolumeXII_5/article4.htm



The four-quadrant model provides a conceptual framework for understanding the range of co-occurring conditions and the level of coordination that service systems need to address them.

SOURCE: SAMHSA News. September/October 2004. Volume 4, #5. http://alt.samhsa.gov/samhsa_news/VolumeXII_5/article4_3.htm

The Last Word

by Joan Cassidy, Chemical Dependency Bureau Chief

Of the many difficult issues chemical dependency treatment providers face, co-occurring disorders may be the most complex. Unfortunately, they are far from uncommon. As noted throughout this publication, about 60 percent of the people served through the chemical dependency treatment system have a co-occurring serious mental illness. At the same time, about 60 percent of those who turn to the mental health treatment system have a co-occurring substance abuse disorder. Co-occurring disorders are so prevalent that they can be considered an expectation rather than an exception.

For many years, the chemical dependency and mental health systems have existed like uneasy neighbors—maintaining separate treatment beliefs, separate policies . . . separate lives. For a number of reasons, we've worked with common clients through separate systems, thus resulting in a potential over-utilization of resources. Currently, services can be duplicative, which makes them more expensive. Even so, individuals with co-occurring psychiatric and substance use disorders are recognized as a treatment population with poor outcomes and high health costs in multiple clinical domains.

The Mental Health Services and Chemical Dependency bureaus are no longer working in isolation. We know there is a better way to address co-occurring disorders at the individual and at the systems levels. It is our shared vision to create a system that supports the needs of the clients we both serve. At the Addictive and Mental Disorders Division, our agencies are working hard to create a more cohesive and collaborative system. We are focused on becoming cohesive partners—creating a system of care that emphasizes improved access and outcomes, and that increases efficiency of resource utilization.

Through a joint venture between the bureaus, a partnership with Kenneth Minkoff, MD and Christie Cline, MD has been developed. Both are nationally respected for their work in creating co-occurring capable systems of care. They will assist the state in building a system of care that is welcoming, accessible, integrated, continuous and comprehensive from the perspective of consumers and families. Ultimately, we are working toward creating *one* system fully equipped to treat the person who has a co-occurring disorder.

CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

*A joint publication of the **Prevention Resource Center** and the **Addictive and Mental Disorders Division***

MONTANA Department of Public Health & Human Services

1,500 copies of this public document were published at an estimated cost of $2.57 per copy, for a total cost of $3,854.00, which includes $3,441.00 for production and printing and $413.00 for distribution.

Montana Prevention Resource Center
P.O. Box 4210
Helena, MT 59604

**PRSPT
STD RATE
U.S. Postage
Paid
Permit No. 246
Helena, MT**